MEDICAL ASSISTANCE PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

Attached is the Medical Assistance Provider Enrollment & Trading Partner Agreement form that is used for enrollment as a provider in the Michigan Medicaid and the State Medical Programs.

The Agreement is also used for enrollment as a provider in the Michigan Children's Special Health Care Services (CSHCS) Program. To deliver specialty care as a CSHCS provider you must include proof of board certification regarding your specialty and subspecialty. Enrollment will be based upon established program criteria

Receipt of a properly completed Agreement does not guarantee enrollment in the Medicaid, State Medical, or CSHCS Programs. You must meet all of the general and service specific enrollment criteria established by the Michigan Department of Community Health (MDCH).

The effective date of enrollment for most providers is the date you sign the Agreement (license permitting) if the MDCH receives it within 30 days of the signature date. Effective dates for some providers are determined by certification requirements or other approval dates.

You may request retroactive enrollment in writing. Enclose the request with the Agreement. Retroactive enrollment eligibility does not mean you can bill for services that do not meet established program billing criteria.

Notification regarding enrollment is sent to the service address listed on the Agreement. If you wish to receive notification at a different address, you must supply a pre-addressed mailing envelope or mailing label with your Agreement.

One Medicaid Provider Manual is sent to each service/practice location. The manual contains specific rules on beneficiary eligibility, covered services, and billing limitations. The manual also defines procedures requiring prior authorization, related administrative requirements, and reimbursement methodology.

If you have any questions about this Agreement, please call (517) 335-5492.

MDCH/ Medicaid Payments Division
Provider Enrollment Unit
P.O. Box 30238
Lansing, MI 48909

To be Completed by DCH Staff Only

MEDICAL ASSISTANCE PROVIDER ENROLLMENT & TRADING PARTNER AGREEMENT

Michigan Department of Community Health

Provider ID Number		Eligibility BEGIN Date
Provider Type		Eligibility END Date
Location Code	Group ID Number	M.O. ☐ YES ☐ NO

PROVIDER / APPLICANT INFORMATION:

1. Applicant's Name (see instructions)	2. Prof. Title	3. State License No. (see instructions)	4. Applicant's Soc. Sec. No. (required)
5. Employer's Name (see instructions)		6. EIN No. (proof required)	7. Applicant's Medicare No.

8. Specialties: (PROOF IS REQUIRED) (see instructions)

A. **B.** **C.** **D.**

9. N.A.B.P. Number	10. D.E.A. Number (proof required)	11. C.L.I.A. Number (proof required)	12. FAX Number ( )
13. Administrator's Name (nursing home, hospital, or clinic)		14. This business is: ☐ **Sole Proprietor** ☐ **Non Profit** ☐ **Partnership** ☐ **Corporation** ☐ **501C3** ☐ **Government**	

SERVICE / PRACTICE ADDRESS:			**BILLING ADDRESS: (see instructions)**	
15. Address (No. & Street)	16. PO Box		22. Address (No. & Street)	23. PO Box
17. City	18. County		24. City	25. State
19. State / 20. Zip Code	21. Business Phone No. ( )		26. ZIP Code	27. Phone No. ( )

CORRESPONDENCE INFORMATION:

28. Address (No. & Street)	29. PO Box
30. City	31. County
32. State	34. Email address:
If Trading Partner is a Provider who elects to receive an 835, and Trading Partner uses multiple submitters, Trading Partner must designate one recipient for all 835 electronic remittance advices:	35. Unique Receiver ID or Name

OWNERSHIP INFORMATION: This is Required if a Corporation or Business *(List the individual owners/ Use additional sheet if necessary)*

36. Owner's Name **A.**	37. Date of Ownership	38. % Owned %	39. Owner's Soc. Sec. No.
40. Owner's Name **B.**	41. Date of Ownership	42. % Owned %	43. Owner's Soc. Sec. No.
44. Owner's Name **C.**	45. Date of Ownership	46. % Owned %	47. Owner's Soc. Sec. No.

OWNERSHIP INFORMATION: List Ownership Interest in Other Entities reimbursable by Medicaid and/or Medicare *(Use additional sheet if necessary)*

48. Owner's Name **A.**	49. Entity Name	52. Owner's Name **B.**	53. Entity Name
50. Entity Address (No. & Street, City, State, Zip Code)		54. Entity Address (No. & Street, City, State, Zip Code)	
51. Entity Federal Tax Identification Number		55. Entity Federal Tax Identification Number	

IMPORTANT: FACSIMILE SIGNATURES WILL NOT BE ACCEPTED

56. Signature of Applicant	57. Date Signed	58. Criminal Convictions relating to Title XVIII, Title XIX, or Title XX: ☐ NO ☐ YES (If YES, see instructions.)

Anyone employing the "applicant" (see box 1), who is the employer / owner of the business listed in box 5, must also sign this agreement in box 65.

59. Employer/ Owner or Agent Name (PRINT)	60. Employer/ Owner or Agent Title (President, Owner, Manager, etc.)	
61. Employer/ Owner or Agent Signature (see instructions)	62. Date Signed	63. Employer/ Owner or Agent Telephone Number

By signing this agreement, I assert that I have read and agree to the Conditions included on pages 2 – 4.

Mail completed form to: MDCH/ Medicaid Payments Division,
Provider Enrollment Unit,
PO Box 30238
Lansing MI 48909

IMPORTANT

- Conditions 1 through 15 apply to all applicants.
- Conditions 17 through 21 apply to all parties engaged in an employer-employee relationship as stated in the following conditions.
- Trading Partner Provisions apply to all electronic billers.
- Either party, upon thirty (30) days written notice, may cancel this Agreement.

Medical Assistance Provider Enrollment & Trading Partner Agreement – Conditions

In applying for enrollment as a provider or trading partner in the Medical Assistance Program (and programs for which the Michigan Department of Community Health (MDCH) is the fiscal intermediary), I represent and certify as follows:

1. The applicant and the employer certify that the undersigned have the authority to execute this Agreement.
2. Enrollment in the Medical Assistance Program does not guarantee participation in MDCH managed care programs nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished on this Medical Assistance Provider Enrollment & Trading Partner Agreement form is true and complete.
4. The applicant and the employer agree to provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (XIX), Title XX, or Title XXI involvement.
5. Before billing for any medical services I render, I will read the Medicaid Provider Manual from the Michigan Department of Community Health (MDCH). I also agree to comply with 1) the terms and conditions of participation noted in the manual, and 2) MDCH's policies and procedures for the Medical Assistance Program contained in the manual, manual updates, provider bulletins and other program notifications.
6. I agree to comply with the provisions of 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.
7. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to, or on behalf of, a Medical Assistance Program beneficiary. These records also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or other healthcare provider.
8. I agree to include a clause in any contract I enter into which allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
9. I understand that payment for services billed under my provider identification number assigned by MDCH will be made directly to me, unless Item 19 (below) applies.
10. I am not currently suspended, terminated, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.
11. I agree to comply with all policies and procedures of the Medical Assistance Program when billing for services rendered. I also agree that disputed claims, including overpayments, may be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction. I further agree to reimburse the Medical Assistance Program for all overpayments, and I acknowledge that the Medicaid Audit System, which uses random sampling, is a reliable and acceptable method for determining such overpayments.
12. I agree to comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR Parts 160 and 164, Subparts A and E). I also agree to comply with the HIPAA security regulations, as applicable, for electronic protected health information, by the compliance date, which is currently April 21, 2005 (45 CFR Parts 160 and 164 Subparts A and C). If I am an electronic biller, I will abide by the Trading Partner Section of this Agreement, and the HIPAA regulations regarding electronic transactions and code sets, as applicable. (45 CFR Parts 160 and 162).
13. This Agreement shall be governed by the laws of the State of Michigan and applicable federal law including, but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
14. The provisions of this Agreement are severable. If any provision is held or declared to be illegal, invalid or unenforceable, the remainder of the Agreement will continue in full force and effect as though the illegal, invalid or unenforceable provision had not been contained in this Agreement.

15. Failure or delay on the part of either party to exercise any right, power, privilege, or remedy in this Agreement will not constitute a waiver. No provision of this Agreement may be waived by either party except in writing signed by an authorized representative of the party making the waiver.

Condition 16 applies to nursing facilities only:

16. If the nursing facility named on the Medical Assistance Provider Enrollment & Trading Partner Agreement is sold, the seller will notify MDCH of the sale at least ninety (90) days prior to the expected sale date. Further, it is understood that the sale will not be recognized for reimbursement purposes under the Medical Assistance Program until ninety (90) days after such notification. Provisions of 42 CFR 413.135(f) will be retrospectively satisfied at that time. Any exception must be approved in writing by MDCH.

Medical Assistance Provider – Employer/Employee Conditions

17. The **applicant** is employed by the business listed, now referred to as the "**employer**", to provide Medical Assistance Program services to eligible beneficiaries at the service address listed.
18. The **employer** shall use the **applicant's** Medical Assistance provider identification number assigned at the service location when billing for Medical Assistance Program services provided by the applicant to eligible beneficiaries.
19. The **applicant**, as a condition of employment, agrees that the employer shall directly receive the payments made in his/her name by the Medical Assistance Program for services billed and paid for eligible beneficiaries.
20. The **employer** and the **applicant** shall advise MDCH within thirty (30) days after any changes in the employment relationship.
21. The **employer** and the **applicant** agree to be jointly and severally liable for any overpayments billed and paid under Act No. 280 of the Public Acts of 1939, as amended, for services provided by the applicant to eligible beneficiaries.

Trading Partner Provisions

The MDCH and its Trading Partner desire to facilitate the exchange of health care transactions ("Transactions") by electronically transmitting and receiving data in agreed formats in substitution for conventional paper-based documents.

1. **Companion Documents; Standards; Other Documentation.**
   MDCH makes available certain inbound and outbound Electronic Data Interchange (EDI) transaction sets/formats and associated version. From time to time during the term of this Agreement, MDCH may modify supported transaction sets/formats. In submitting Transactions to MDCH, Trading Partner agrees to conform to MDCH-issued provider publications and MDCH Companion Guides as amended from time to time. The MDCH Companion Guides, incorporated by reference herein, contain specific instructions for conducting each Transaction and as such supplement Implementation Guides issued under the Standards for Electronic Transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended. The MDCH Companion Guides are not intended to be complete billing instructions and do not alter or replace applicable physician guides or other healthcare provider billing publications issued by MDCH or by other third party payers. The Trading Partner agrees to comply with the requirements set forth in the applicable MDCH Companion Guides. The Trading Partner, or its vendor, or other authorized technical representative responsible for EDI software will document Trading Partner Information, data formats, and related versions, trading partner identifiers and other information MDCH requires to receive and transmit specific Transactions supported by MDCH.
2. **Support.**
   As to software, equipment, and services associated with each party's performance under this Agreement, the parties agree to provide support services sufficient for Transactions to be exchanged. Each party will assist the other in establishing and/or maintaining support procedures, and will complete appropriate problem determination procedures prior to contacting the other with a support related matter. The parties agree to use all commercially reasonable efforts to avoid and resolve performance and unavailability issues. Each party will perform remedial action as requested by the other to assist in problem resolution. Each party, at its own expense, shall provide and maintain the equipment, software, services, and testing necessary to effectively and reliably transmit and receive transactions.
3. **Data Retention.**
   MDCH will log all Transactions for the purposes of problem investigation, resolution, and servicing. The Trading Partner is responsible for maintaining and retaining its own records of data submitted to MDCH. Trading Partners who are healthcare providers will ensure that electronic healthcare claims submitted to MDCH can be readily associated and identified with the correct patient medical and business office records, and that these records are maintained in a manner that permits review and for the time period as may be required by MDCH or other third party payer responsible for claim payment.

4. **Proper Receipt and Verification for Transactions.**
   Upon proper receipt of any ANSI ASC X12N Standard Transaction, the receiving party shall promptly and properly transmit a functional acknowledgement in return, unless otherwise specified. The functional and interchange acknowledgements must be accepted and reviewed, when applicable, to confirm the receipt of a Transaction. The ability to send or receive functional acknowledgements is applicable only to ANSI ASC X12N Standard Transactions. Additionally, MDCH originated outbound Transactions must be accepted and reviewed when appropriate, to obtain MDCH's response to specific inbound Transactions. The acknowledging party does not attest to the accuracy of the data contained in the transmission; rather, it only confirms receipt of the transmission.

5. **Liability.**
   MDCH shall not be responsible to the Trading Partner nor anyone else for any damages caused by loss, delay, rejection, or any misadventure affecting such electronic information. In addition, MDCH shall be excused from performing any EDI service or function, in whole or in part, as a result of an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including shortages or fluctuations in electrical power, heat, light, or air conditioning. MDCH's sole liability to the Trading Partner or to any other person or entity in connection with MDCH's responsibilities under this Agreement shall be to reprocess information supplied by the Trading Partner or duplicate information from a backup supplied by the Trading Partner upon MDCH's request which shall be the sole remedy against MDCH for claimed damage or injury of any nature. MDCH shall not be liable for any indirect, special, or consequential damages arising out of any access, use, or any reliance upon, the EDI services MDCH provides to the Trading Partner. MDCH assumes no responsibility for claims preparation, review, information accuracy, pricing, adjudication, payment, adjustment, accounting, reconciliation or any other matter related to the claims transmitted for delivery to other third party payers. The Trading Partner agrees to defend, indemnify, and hold harmless MDCH, its Trading Partners, officers, agents, employees, assigns and successors from and against any and all claims, losses, and actions, including all costs and reasonable attorney fees, arising out of electronic Transactions the Trading Partner submits to MDCH.

6. **Standard Transactions.**
   All Standard Transactions, as defined by HIPAA, will be conducted by the parties only using code sets, data elements, and formats specified by the Transaction Rules, and instructions in the MDCH Companion Guides. The parties agree that when conducting Standard Transactions, they will not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.

7. **Testing.**
   All new Trading Partners will cooperate with MDCH upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with MDCH upon request in testing processes for any changes in submission format prior to submission of production files. MDCH will notify the Trading Partner of the effective date for production data after successful testing.

8. **Data and Network Security.**
   The parties agree to use reasonable security measures to protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with MDCH data and network security requirements, which may change from time to time and as may be required by the HIPAA security regulations.

9. **Automatic Amendment for Regulatory Compliance.**
   This Agreement will automatically be amended to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

10. **Miscellaneous.**
    Provisions 3 and 8 shall survive termination of this Agreement.

    The Trading Partner will notify MDCH of any changes in trading partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at least 30 calendar days prior to the effective date of such change.

Instructions

Photocopies of this form must NOT be used to request enrollment.

This form is to be completed by all eligible providers who wish to receive payment for services provided under the programs for which the Medical Services Administration serves as the fiscal intermediary.

TYPE or PRINT in BLACK INK.

An **original** enrollment agreement must be submitted for **each** service/office and for **each** eligible provider rendering services. Note: Photocopies of the application will **not** be accepted. Only the items needing clarification are listed below.

APPLICANT NAME (Box 1): Physicians, CRNAs, Nurse Midwives, Nurse Practitioners, Private Duty Nurses, Dentists, Independent Physical Therapists, and Hearing Aid Dealers must enter their last name, first name and middle initial **as licensed**. All other applicants must enter the complete business name **as licensed.**

STATE LICENSE NUMBER (Box 3): Applicants must submit the following documentation:

All **out-of-state**, newly licensed, and limited / temporary licensed applicants **must** supply a copy of their current state license.

- Ambulance: a copy of your state license.
- Hearing Aid Dealer: a copy of your state license.
- Hospice: copies of your state license and Medicare certification.
- Nurse Midwife: copies of your current state RN license and state specialty certification.
- Nurse Practitioner: copies of your current state RN license, and state specialty certification as a nurse practitioner.
- CRNA: copies of your current state RN license and state specialty certification as a nurse anesthetist.
- Private Duty Nurse (RN & LPN): a copy of your current state license.

EMPLOYER NAME (Box 5): If you are employed or contracted by a business or in a partnership, enter the name of the business you are employed by or affiliated, contracted, or in partnership with.

EMPLOYER IDENTIFICATION NUMBER (EIN) (Box 6): Enter the Federal Employer Identification Number (EIN) of the business listed. PROOF IS REQUIRED. Supply a photocopy of the EIN received from the federal government.

SPECIALTIES (Box 8): Specialty data **will not be added** to your enrollment record **without proof**.

Attach the following documentation of specialties:

- Physician: proof of board certification.
- Dentist: a copy of the state specialty license.
- Home Health Agency: a copy of the Medicare certification/approval letter.
- Clinical Laboratory: copies of the CLIA Certificate and HCFA-116 form.

NONPROFIT (Box 14): Freestanding clinics that receive federal, state, or local funds must attach a statement describing the (a) source of funding, and (b) distribution of funds. Nonprofit organizations do not complete Boxes 36-47.

BILLING ADDRESS (Boxes 22 – 27): Complete this address **only** if you want checks, remittance advices, and IRS 1099 forms sent to an address other than the Service Address.

CORRESPONDENCE INFORMATION (Boxes 28 – 33): Complete this address only if you want letters, bulletins, and etc. from MDCH sent to an address other than the Service Address.

E-MAIL ADDRESS (Box 34): Please complete this to be included in MDCH Listserve.

UNIQUE RECEIVER ID OR NAME (Box 35): The Unique Receiver ID or Name is assigned to the Corporation as identified in Box 6. **All providers** under that corporate Tax Identification Number (TIN) must indicate the same Unique Receiver ID or Name. **This Unique Receiver ID or Name will be the entity to receive the 835 Health Care Payment/ Advice Transactions for providers under the same TIN.**

CRIMINAL CONVICTIONS (Box 58): 42 CFR 455.106 requires the State to collect criminal conviction information, related to Medicare (Title XVIII), Medicaid (Title XIX), or any Title XX program, about any person who has an ownership or control interest, or is a managing employee of the provider. If this applies, provide information and/or documentation on a separate page.

EMPLOYER/OWNER OR AGENT SIGNATURE (Box 61): The employer/owner or agent of the business listed in Box 5 employing the applicant must also sign the enrollment agreement.

COMPLETED FORM: Submit the original form to:

MDCH/ Medicaid Payments Division
PROVIDER ENROLLMENT UNIT
P.O. BOX 30238
LANSING, MI 48909

Retain a photocopy of the completed DCH-1625 form for your records.

Instructions

Special Instructions: *The following applicants must submit the* ***additional*** *documentation:*

AMBULANCE – GROUND BASED (Neonatal Transport): A copy of your neonatal approval letter from the regional perinatal center.

AMBULANCE – FIXED WING: A copy of your Commission on Accreditation of Air Medical Services (CAAMS) Certificate.

AMBULANCE – HELICOPTER (Rotary): Copies of your state license and Certificate of Need (C.O.N.).

CLINICAL LABORATORY: Copies of the HCFA-116 form and Clinical Laboratory Improvement Amendments (CLIA) Registration Certificate or CLIA Certificate of Accreditation or Compliance.

END-STAGE RENAL DISEASE (ESRD) FACILITY: A copy of Medicare's Certification Letter.

HOME HEALTH AGENCY & SUBUNIT(S): A copy of Medicare's Certification letter, and a letter stating the applicant's fiscal year end.

HOSPICE: A letter stating the applicant's fiscal year end.

INDEPENDENT PHYSICAL THERAPIST/REHABILITATION AGENCY: A copy of Medicare's certification letter.

MATERNAL/INFANT SUPPORT AGENCY: A copy of the approved Michigan Department of Community Health Maternal/Infant Support Services Provider Application.

MEDICAL SUPPLIER (DME): A list or brochure describing the supplies/equipment that you will provide and a copy of your state license or state sales tax license.

OPTOMETRIST: A copy of your Therapeutic Pharmaceutical Agents Certificate.

ORTHOTICS AND PROSTHETICS: A copy of your Certificate from the American Board of Orthotics and Prosthetics, Inc.

PRIVATE DUTY AGENCY: A copy of your accreditation by Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Community Health Accreditation Program (CHAP), or Commission on Accreditation of Rehabilitation Facilities (CARF).

SCHOOL BASED SERVICES (Intermediate School Districts): A copy of the Department of Education Certification to provide these services.